BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	
RAYMOND M. MENCHACA, M.D.	Case No. 11-2013-233166
Physician's and Surgeon's Certificate No. G75144	OAH No. 2016070635
Respondent	

DECISION

The Proposed Decision of Howard W. Cohen, Administrative Law Judge, dated June 21, 2017 is attached hereto. Said decision is hereby amended, pursuant to Government Code section 11517(c)(2)(C), to correct technical or minor changes that do not affect the factual or legal basis of the proposed decision. The proposed decision is amended as follows:

1. Pages 14, paragraph 13, second line, subdivision (d) is stricken and replaced with subdivision (c).

The Proposed Decision as amended is hereby accepted and adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on August 23, 2017.

IT IS SO ORDERED: July 24, 2017.

MEDICAL BOARD OF CALIFORNIA

Michelle Anne Bholat, M.D., Chair
Panel B

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: RAYMOND M. MENCHACA, M.D., Physician's and Surgeon's Certificate Number G 75144, Respondent.	Case No. 11-2013-233166 OAH No. 2016070635

PROPOSED DECISION

Howard W. Cohen, Administrative Law Judge (ALJ), Office of Administrative Hearings (OAH), State of California, heard this matter on May 15 through 18 and 22, 2017, in Los Angeles.

Christine R. Friar, Deputy Attorney General, represented complainant Kimberly Kirchmeyer, Executive Director of the Medical Board of California (Board), Department of Consumer Affairs (Department), State of California.

Henry Fenton and Nicholas Jurkowitz, Attorneys at Law, represented respondent Raymond M. Menchaca, M.D., who was present.

Complainant moved at hearing to amend the Accusation to eliminate all reference to Patient E.P., as follows: delete page 6, paragraphs 38 to 41; page 14, lines 5 and 16; page 15, line 2. The motion, unopposed, was granted.

Oral and documentary evidence was received. The record was closed and the matter was submitted on May 22, 2017.

Protective Order

Complainant moved for a protective order sealing exhibits to protect confidential information concerning third parties; respondent made no objection. The ALJ issued a protective order dated June 21, 2017. Redaction of those documents subject to the protective order, to obscure confidential information, was not practicable and would not have provided adequate privacy protection. Those exhibits shall remain under seal and shall not be opened,

except by order of the Board, by OAH, or by a reviewing court. The ALJ ordered that every court reporter refer in the hearing transcript to respondent's patients by initials only.

SUMMARY

Complainant seeks to discipline respondent's medical license on grounds of alleged gross negligence, repeated negligent acts, inadequate recordkeeping, and failure to document supervision of physician assistants in connection with care and treatment provided to five patients. Respondent denies the allegations and asserts cause for discipline does not exist.

FACTUAL FINDINGS

Jurisdiction

1. Complainant filed the Accusation in her official capacity. Respondent timely filed a notice of defense.

2. The Board issued Physician's and Surgeon's Certificate No. G 75144 to respondent on September 8, 1992. Respondent's certificate was in full force and effect at all relevant times and is scheduled to expire on June 30, 2018.

3. Respondent received his medical degree in 1991 from the University of California, Irvine. Following graduation, respondent completed a one-year internship and a two-year residency in family practice at the San Bernardino County Medical Center.

4. Respondent is the supervising physician and 51 percent owner of Zacoalco Medical Group, Inc. (Zacoalco Clinic or Clinic), where he has practiced family medicine since 1997. The Zacoalco Clinic has a Los Angeles location and a Bakersfield location, as well as an urgent care center in Los Angeles. Respondent currently supervises one physician assistant (PA) at each location. The Zacoalco Clinic patient population consists primarily of Medi-Cal patients, mostly Hispanic. Clinic patients require pediatric care, preventative care, and chronic illness management, and have a high frequency of obesity, alcohol use, and hypertension. Respondent visits the Los Angeles and Bakersfield locations every other week, on alternate Thursdays, when he reviews charts and sees certain patients. On the other four weekdays, respondent works at a hospital-owned clinic in Fillmore.

5. Respondent's medical certificate has not previously been disciplined.

Respondent's Physician Assistants

6. Several PA's have worked at the Clinic under respondent's supervision. Most of the patient charts in evidence in this matter include those prepared by PA's Saul de la Rosa and Jacqueline Surrency, who both testified. De la Rosa has worked as a PA at various Clinic locations, of which he is a 49 percent owner, since the Clinic opened in 1997. Since 2011, Jacqueline Surrency has worked as a PA in the Clinic's Los Angeles location continuously

except for a one and one-half year hiatus when she worked at another clinic not owned by respondent.

7. Respondent and the Clinic's PA's, including de la Rosa and Surrency, entered into a "Delegation of Services Agreement Between Supervising Physician and Physician Assistant (Title 16, CCR, Section 1399.510)" (Delegation Agreement).[1] (Exs. 3, 4.) The "Authorized Services" section of the Delegation Agreement authorizes the tasks listed in regulations governing physician assistants,[2] and provide that each PA "will be supervised as outlined in the Clinic's 'Guidelines for Supervision of Physician Assistants' . . . ." (*Ibid.*)

8. No document with that title was offered in evidence. Accompanying the Delegation of Services Agreements, however, is a document entitled "Supervising Physician's Responsibility for Supervision of Physician Assistant." (Ex. 3, p. 12; Ex. 4, p. 13.) The responsibility statement requires respondent to supervise his PA's in accordance with Business and Professions Code section 3502 and CCR section 1399.545. It requires each PA to "enter the name of his or her supervising physician" each time the PA provides patient care and enters his or her name or initials on a patient's record. (*Ibid.*) It provides that respondent will "audit the medical records of at least 5% of patients seen by the PA under any protocols which shall be adopted by the supervising physician and the physician assistant. The physician shall select for review those cases which by diagnosis, problem, treatment, or procedure represent, in his or her judgment, the most significant risk to the patient." (*Ibid.*)

9. No written protocols were offered in evidence. In his testimony, however, respondent described how records were selected for his review. He instructed the Clinic's office manager and the PA's to select, from the charts of patients who had been seen by PA's during the preceding two weeks, those patients with complicated continuing care issues, mostly older Medicare patients. When respondent visits the each Clinic location every other Thursday, he reviews more than 60 charts, which is at least five percent of all the charts. Respondent also asks and answers questions of the PA's, and he looks at laboratory results if a PA needs assistance. When not visiting the Clinic, respondent responds immediately to telephone inquiries from the PA's.

10. Over the years, respondent has observed each new PA interact with patients, and has engaged them in regular discussions regarding patients and their conditions. Once he assures himself that his PA's are competent to do their work, that they are practicing within the scope of their competency, that charts are sufficiently legible to allow him to assess patient care, and that appropriate laboratory testing was being ordered and medication prescribed, respondent cuts back his record review to five to ten percent of the charts. If he has a question about a patient chart, he asks the PA to clarify the matter. But for the most part, even if a chart is not

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[1] "CCR" refers to the California Code of Regulations. Further references herein to the CCR are to title 16 thereof.

[2] See CCR, § 1399.541, subds. (a), (d), (e), (f), and (g).

entirely legible to him, respondent trusts his PA's, having worked with them for some years, to perform appropriate examinations, make appropriate referrals, and provide appropriate care.

11. Respondent believes Surrency and de la Rosa are very good PA's. They practice within the scope of their training, are conscientious, and take time to educate patients about their health. When respondent asks them to clarify their notes, they demonstrate that they are practicing appropriately.

12. The Delegation of Services Agreement requires each PA to enter on each patient chart the name of the supervising physician. The Clinic's PA's have become noncompliant with that requirement over time.

Expert Witnesses

13. Complainant called Timothy Munzing, M.D. as an expert witness. Dr. Munzing is board-certified in family practice and is engaged in the private practice of family medicine with the Southern California Permanente Medical Group. Respondent's expert witness, Richard A. Johnson, M.D., is a board-certified family practitioner engaged in the private practice of family medicine at a clinic in Pacific Palisades.

14. Both experts testified as to the standard of care with respect to a physician's supervision of PA's generally, and with respect to the care provided to six Zacoalco Clinic patients. Respondent did not review, in the course of his supervision, any of the charts for the six patients considered here; as it happens, they were not among the five to ten percent of patient charts respondent reviewed.

15. Dr. Munzing testified that respondent was responsible for the appropriateness of care provided by, and the documentation of that care by, the PA's under his supervision. As the supervising physician, respondent should be able to articulate the reasons for a diagnosis and course of action from the PA's patient records. Dr. Munzing opined that respondent's supervision of the PA's at the Clinic was inadequate.

16. Dr. Johnson testified that respondent's overall supervision of his PA's was within the standard of care. Physicians do not have an independent obligation to involve themselves in the care of the PA's patients. PA's treat patients under a Delegation of Services Agreement, and here there were no complex issues warranting respondent's involvement in the cases of the six patients under review. To ensure that PA's are providing appropriate care, supervising physicians are not responsible to do more than hire PA's who are appropriately trained and credentialed, address any departures if observed, and review five percent of patient files to verify that appropriate care has been provided. Chart legibility is of secondary importance.

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Patient A.H.[3] *and Expert Testimony*

17. On October 25, 2012, Patient A.H. presented at Zacoalco Clinic, where she received medical care and treatment from two PA's. The purpose of the visit was to refill medication. Patient A.H. had previously been diagnosed with asthma and hypertension. Patient A.H. again presented at Zacoalco Clinic on December 27, 2012 and she was again treated by a PA. The purpose of the visit was to obtain lab results, which showed that A.H. had anemia.

18. Dr. Munzing testified that, during the course of Patient A.H.'s care and treatment at Zacoalco Clinic, A.H.'s past medical history was insufficiently documented to justify the medications prescribed; the examinations performed on A.H. were minimal and insufficient to justify the medications and treatments prescribed; an appropriate examination was not performed at her December 27, 2012 visit pertaining to her anemia, including performing a rectal exam, nor was an appropriate anemia evaluation performed, including additional laboratory testing; medications were prescribed with no documented justification or explanation; diagnoses were listed without supporting information; injection medications were administered without justification; nebulizer treatments were given without adequate justification; illegible notes were made in her chart, including but not limited to those pertaining to physical examinations, assessments, and treatment plans;[4] and respondent's failure to adequately supervise, evaluate, manage, and document A.H.'s care on multiple dates constitutes an extreme departure from the standard of care.

19. For example, Dr. Munzing testified, at the October 25, 2012 visit, the patient was administered Clonidine after having a high blood pressure reading. Obesity should be mentioned in this record, but it is not. There is no documentation in her chart as to whether the patient was taking her medications, whether her respiratory rate was checked, or whether after receiving the Clonidine the patient's blood pressure was taken again. Most of the notes in Patient A.H.'s medical record for this visit are not legible. Injections of Rocephin, an antibiotic, and Decadron, a corticosteroid hormone, were ordered, but the reason for administering the injections is not reflected in Patient A.H.'s records. It also appears from the record of her October 25, 2012 visit, that Patient A.H. received a nebulizer treatment; there is no documentation of a need for the nebulizer treatment, or what medication was delivered by nebulizer, and the patient's her lung exam was normal.

20. Also, during the patient's December 27, 2012, visit, for lab results, no pulse, respiratory rate, or blood pressure was noted in the chart. There was no documentation of the patient's history of anemia, and the record does not indicate whether the cause of the patient's anemia was identified. The PA prescribed iron, but the chart does not indicate whether an iron deficiency caused the anemia. There is little risk from giving iron while continuing to try to

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[3] Initials have been used for all patients to protect their confidentiality.

[4] Zacoalco Clinic has been using electronic medical records since 2013 or 2014.

diagnose, but there is no record of an attempt to rule out more serious problems. The chart again does not state what medication was delivered by nebulizer, or for what reason.

21. Respondent testified that the chart shows the PA used a nebulizer for the patient's asthma, which was listed in the diagnosis. Nebulizers in a family care or emergency room setting are usually given for fast-acting relief; only a few medications are appropriate, including Leva-Albuterol and Ipratropium, but the most common is Albuterol, which Zacoalco Clinic uses. A previous blood test showed Patient A.H. had mild anemia; it is common to give an iron challenge test, prescribe iron, wait four to six weeks, and re-test. Patient A.H. was ambulatory and fairly stable, and did not appear ill, so it was appropriate to treat her first and repeat blood tests later. Respondent trusts that the PA's examined the patient, who showed asthma and the possibility of infection, and used Recephin to try to stop the infection. Decadron helps clear the lungs of asthma-caused secretions. If some details of an examination are not documented, respondent still trusts that an appropriate examination was performed, given his experience with his PA's.

22. Dr. Johnson testified that patients treated at Zacoalco Clinic were ongoing patients. Because the PA's and respondent see each of them numerous times, Dr. Johnson opined, more detail in the charts is unnecessary unless there were sustained omissions of highly relevant information. The evidence shows, however, that there were significant omissions of information that a subsequent provider would find useful, and the omission of the name of the supervising physician was a violation of the governing statute and regulations and the Delegation of Services Agreements. Those statutes and regulations also require the records to be legible to the supervising physician. Dr. Johnson further testified, more convincingly, that the fact that the charts do not state what medication was delivered by nebulizer is not necessarily a deviation from the standard of care. The standard medication for nebulizer delivery at a family clinic like Zacoalco Clinic would be a beta agonist, probably Albuterol. Also, treatment provided to Patient AH was within the standard of care. Patient A.H. was a post-menopausal woman with lab work showing anemia. A therapeutic trial of iron is appropriate. If there were no improvement at the next visit, after confirming that the patient actually took the iron, the appropriate plan would be to look at possible blood loss, hemolysis, medications, uterine bleeding, and other possible causes of anemia.

Patient D.E. and Expert Testimony

23. Between October 2012 and April 2014, Patient D.E., born in April 2012, presented at Zacoalco Clinic numerous times, where he received medical care and treatment from PA's. On numerous visits, Patient D.E. presented with bronchitis or an upper respiratory infection and was treated with injections of medications including, Dexamethasone IM and prednisone, both steroids.

24. Dr. Munzing testified that, during the course of Patient D.E.'s care and treatment at Zacoalco Clinic, D.E.'s past medical history was insufficiently documented to justify the medications prescribed; the examinations performed on D.E. were minimal and insufficient to justify the medications and treatments prescribed; medications were prescribed with no

documented justification or explanation; diagnoses were listed without supporting information; injection medications were administered without justification; illegible notes were made in his chart, including but not limited to those pertaining to physical examinations, assessments, and treatment plans; and respondent's failure to adequately supervise, evaluate, manage, and document D.E.'s care on multiple dates constitutes an extreme departure from the standard of care.

25. For example, Dr. Munzing testified about Patient D.E.'s January 23, 2013 visit.[5] The patient presented with a cough, fever, phlegm, and vomiting. An adequate exam was not performed. The diagnosis and prescriptions were mostly illegible. Three days later, the patient returned, having had chest congestion for one week. There was minimal history recorded, and the notes of the examination were illegible. On January 2, 2014, the PA diagnosed croup without explaining how the diagnosis was made. The chart for an April 1, 2014 follow-up visit did not indicate whether the patient was improving or getting worse. The patient's respiration rate was not recorded.

26. Respondent testified that the charts showed no infectious process, neither viral nor bacterial, and the notation of "allergies" was appropriate to explain the patient's chief complaint of coughing and phlegm and to support the medications administered.

27. Dr. Johnson testified that there was no deviation from the standard of care. The infant patient began receiving healthcare at the Clinic shortly after birth, followed by a variety of well-child visits. The charts show appropriate monitoring, with episodic urgent problems appropriately addressed.

Patient E.A. and Expert Testimony

28. Between March 5, 2010 and November 21, 2013, Patient E.A. presented at Zacoalco Clinic on at least 20 different occasions and was treated by various PA's. Patient E.A. sought treatment and medication management for hypertension and elevated glucose levels, among other conditions.

29. Dr. Munzing testified that, during the course of Patient E.A.'s care and treatment at Zacoalco Clinic, E.A.'s past medical history was insufficiently documented to justify the medications prescribed; the examinations performed on E.A. were minimal and insufficient to justify the medications and treatments prescribed; medications were prescribed with no documented justification or explanation; diagnoses were listed without supporting information; illegible notes were made in his chart, including but not limited to those pertaining to physical examinations, assessments and treatment plans; and respondent's failure to adequately

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[5] Dr. Munzing also opined about visits with this patient and other patients outside the time range of the allegations in the Accusation. Those opinions, except where they may reflect on actions taken during the time range alleged, are not deemed relevant.

supervise, evaluate, manage, and document Patient E.A.'s care on multiple dates constitutes an extreme departure from the standard of care.

30. For example, on a visit in April 2010, Dr. Munzing testified, the patient's blood pressure, 180/102, was out of control, indicating it was not adequately being managed. This is a patient respondent should have looked at personally. The record does not reflect an attempt to address the causes of the patient's hypertension, despite his history of stroke. On a July 10, 2010 visit to refill medications, the records are entirely illegible. Dr. Munzing testified that legibility is a consistent problem in all the patient charts. Respondent should have told the PA's that he cannot read what they are writing. On an October 8, 2010 visit, there is no documentation of blood pressure or of a physical examination. On the next visit a month later, no vitals are documented, nor is there documentation of whether the course of treatment has been effective. On July 20, 2012, an ultrasound of the patient's groin was ordered, with no documented reason.

31. Respondent testified that Patient E.A.'s blood pressure was elevated but not out of control. It was treated by conventional, appropriate methods; the patient was given medications and asked to keep a log. Patient E.A. is an established patient, well-known to the PA's and to respondent. The exams were sufficient to justify the laboratory tests ordered and the medications prescribed. He is not necessarily someone who should have been referred to respondent's attention; the PA's are trained to see patients like this.

32. Dr. Johnson testified there was no deviation from the standard of care. The PA's efforts were directed at trying to control Patient E.A.'s blood pressure as best as possible, using appropriate strategies, laboratory tests, and medications.

Patient M.P. and Expert Testimony

33. Between November 19, 2009 and November 27, 2013, Patient M.P. presented at Zacoalco Clinic on at least 35 different occasions and was treated by various PA's. Patient M.P.'s complaints included allergies, sinusitis, breast and lower back pain, and eczema.

34. Dr. Munzing testified that, during the course of Patient M.P.'s care and treatment at Zacoalco Clinic: M.P.'s past medical history was insufficiently documented to justify the medications prescribed; the examinations performed on M.P. were minimal and insufficient to justify the medications and treatments prescribed, and medications were prescribed without documented justification or explanation; diagnoses were listed without supporting information; injection medications were administered without justification; illegible notes were made in her chart, including but not limited to those pertaining to physical examinations, assessments and treatment plans; and respondent's failure to adequately supervise, evaluate, manage and document M.P.'s care on multiple dates constitutes an extreme departure from the standard of care.

35. For example, on February 4, 2010, Patient M.P. complained to de la Rosa of pain in her left ear and in bilateral elbows and knees. De la Rosa documented an examination of the patient's left tympanic membrane, though the note is illegible; he failed to document an

examination of her elbows and knees or whether he took her pulse. The diagnosis and medications prescribed are not legible. On a September 13, 2010 examination for lower back pain, chest pain, and vaginal discharge and itchiness, it is impossible to tell what the examination consisted of and what medications were prescribed. This pattern is consistent throughout this patient's charts.

36. Respondent acknowledged that he could not understand many of the notations on this patient's chart. But he opined that information from prior labs and x-rays are more important than physician notes for the management of the patient by a subsequent provider.

37. Dr. Johnson testified that the care and treatment provided to this patient was within the standard of care.

Patient H.A. and Expert Testimony

38. Between June 2, 2009 and February 11, 2014, Patient H.A. presented at Zacoalco on at least fifteen different occasions and was treated by various physician assistants. Her chief complaints included back, neck, shoulder, elbow and kidney pain.

39. Dr. Munzing testified that during the course of Patient H.A.'s care and treatment at Zacoalco Clinic, Patient H.A.'s past medical history was insufficiently documented to justify the medications prescribed; the examinations performed on H.A. were minimal and insufficient to justify the medications and treatments prescribed; medications were prescribed with no documented justification or explanation; diagnoses were listed without supporting information; injection medications were administered without justification; illegible notes were made in her chart, including but not limited to those pertaining to physical examinations, assessments and treatment plans; and that respondent's failure to adequately supervise, evaluate, manage and document H.A.'s care on multiple dates constitutes an extreme departure from the standard of care.

40. For example, Dr. Munzing testified, on October 30, 2009, Patient H.A. presented with coughing, bone pain, headache, and chest pain. The charts do not reflect adequate history notations regarding chest pain. The examination, diagnosis, and medication notes are for the most part illegible. There is an absence of recorded justification for medications ordered. A similar pattern of inadequate history, minimal and inadequate exams, no logic to diagnoses, and unclear reasons for injections and medications is reflected throughout this patient's records.

41. Respondent and Dr. Johnson offered testimony regarding recordkeeping similar to their testimony regarding the medical records of the Clinic's other patients.

Testimony of Surrency and de la Rosa

42. Surrency testified thoroughly about each entry in her patient charts presented at hearing. She was very familiar with the patients whose charts were in evidence; most are still long-term patients at the Clinic whom she has seen many times. She did not have difficulty interpreting her own handwriting on the charts and most of the handwriting of the other PA's.

Her testimony establishes that, for the most part but not in every instance, appropriate information was recorded, appropriate action was taken, and laboratory tests were ordered and results were addressed with the patient.

43. Surrency's credibility is enhanced not only by her fluid interpretation of the charts but by her ready acknowledgement of several deficiencies in the charts. For example, Surrency explained that, after administering Clonidine to a patient, the PA's routinely wait 30 minutes and again take the patient's blood pressure, recording it either on the chart, or on a "sticky note" attached to the chart, and wait until the blood pressure is at a safe level before releasing the patient. She acknowledged, however, that the second blood pressure readings were not always charted. The charts do not identify the medication applied by nebulizer because the only such medication the Clinic uses is Albuterol, a bronchial dilator; Surrency acknowledged that someone unfamiliar with the Clinic's practice would not know that Albuterol was administered. Though Clinic personnel take each patient's vital signs at every visit, they sometimes do not record the vitals on the patient's chart (as, for example, on Patient A.H.'s December 27, 2012, visit). Though Surrency always performed a head-to-toe physical examination of her patients, she did not always document that fact. For example, on Patient M.P.'s August 4, 2011, visit, though Surrency palpated the patient's joints and upper extremities, she failed to annotate it. Also not explicitly documented, for example, was the basis for her conclusion that iron deficiency was the likely cause of Patient A.H.'s anemia.

44. Surrency acknowledged that her handwritten charts should be but are not always legible to her supervising physician as well as to other physicians who might later have occasion to review the charts. She admitted that the charts in evidence in this case do not identify the supervising physician; she testified that respondent never addressed that requirement with her. Certain notational conventions, such as drawing a line through action items preprinted on the patient charts when the item was performed, would be clearly understood only by someone who works at the Clinic.

45. De la Rosa, who completed a two-year PA program at the University of Southern California, has never taken any recordkeeping courses. De la Rosa's notes were difficult for others to read; in some instances during his testimony they proved difficult even for him to read. Though he was taught in his classes to keep clear, legible progress notes, he acknowledged that over time he began to write notes faster. He thinks his notes are legible to those who work with him, but that did not always prove to be the case at this hearing, and respondent has on occasion asked de la Rosa to write more clearly. When de la Rosa started work at the clinic he regularly entered the name of his supervising physician on each patient record, as required; over time, however, he stopped doing it. De la Rosa had some difficulty explaining some of his diagnoses (e.g., his diagnosis of allergies for Patient D.E. and his conclusion that the patient had a bacterial as opposed to a viral infection). Some of his chronic patient charts did not reflect whether the patient had been compliant with medication orders between visits.

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Overall Patient Care as Reflected in the Records of Patients A.H., D.E. E.A., M.P., and H.A.

46. Dr. Munzing's testimony regarding recordkeeping is found to be more credible and persuasive than Dr. Johnson's, and it is therefore credited when in conflict with Dr. Johnson's. According to Dr. Johnson, the recordkeeping met the minimum requirements of the standard of care, especially since the providers were familiar with the repeat patients at the Clinic. Dr. Munzing's testimony is more closely aligned with the requirements, discussed below, of statutes and regulations governing PA's, which requirements physicians practicing within the standard of care would likely follow.

47. The medical record entries by the PA's were often illegible and at times incomplete, an issue respondent should have taken steps to correct. The charts do not make clear that patients were not being overmedicated. Respondent failed to instruct the PA's under his supervision on requirements that they document on each chart the identity of the supervising physician, pertinent details of the patient history, examination, and the basis for any diagnosis and medication provided. Respondent also failed to take steps sufficient to ensure that patient charts were legible to him and other physicians who might provide care to patients seen at the Clinic.

48. Dr. Munzing's testimony regarding gross negligence and repeated acts of simple negligence is less credible and persuasive, however, than Dr. Johnson's, in view of all the evidence on the record. It was not established, with some exceptions, that the care provided to Zacoalco Clinic patients departed from the standard of care. Nor does the totality of the care demonstrate a pattern of excessive use of injectable medications and other treatments without taking or developing an adequate history, exam, diagnosis, and management plan. Dr. Munzing conceded that, in many cases, the PA's management plan may be correct, though the logic of the plan cannot be ascertained from the records.

LEGAL CONCLUSIONS

Burden of Proof

1. The rigorous education, training, and testing requirements for obtaining a physician's license justify imposing on complainant a burden of proof of clear and convincing evidence. (Evid. Code, § 115; see *Ettinger v. Bd. of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856; *Imports Performance v. Dept. of Consumer Affairs, Bur. of Automotive Repair* (2011) 201 Cal.App.4th 911.)

Applicable Authority

2. The Board is responsible for enforcing the disciplinary provisions of the Medical Practice Act (Bus. & Prof. Code, § 2004, subd. (a)). The Board's highest priority is to protect the public. (Bus. & Prof. Code, § 2229.) A certificated practitioner who violates the Medical Practice Act may have his or her certificate revoked or suspended or placed on probation, or

have "other action taken in relation to discipline" as the Board deems proper. (Bus. & Prof. Code, § 2227.)

3. The Board may discipline a practitioner's certificate for unprofessional conduct, which includes, among other things, a violation of the Medical Practice Act, gross negligence, repeated negligent acts, and a failure to maintain adequate and accurate records of services provided to patients. (Bus. & Prof. Code, §§ 2234, subds. (a)-(c), 2266.)

4. A licensed physician may supervise one or more physician assistants. (See Bus. & Prof. Code, § 3501, subd. (a), definition (5).) "'Supervision' means that a licensed physician and surgeon oversees the activities of, and accepts responsibility for, the medical services rendered by a physician assistant." (Bus. & Prof. Code, § 3501, subd. (a), definition (6).) "A physician assistant acts as an agent of the supervising physician when performing any activity authorized by this chapter or regulations adopted under this chapter." (Bus. & Prof. Code, § 3501, subd. (b).)

5. In this case, as set forth in Factual Finding 6 through 12, respondent assumed the obligation for supervising his PA's, and he is therefore responsible for the medical services they rendered.

6. A PA may only provide those medical services "which he or she is competent to perform and which are consistent with the physician assistant's education, training, and experience, and which are delegated in writing by a supervising physician who is responsible for the patients cared for by that physician assistant." (CCR, § 1399.540.)

7. "A physician assistant and his or her supervising physician and surgeon shall establish written guidelines for the adequate supervision of the physician assistant. This requirement may be satisfied by the supervising physician and surgeon adopting protocols for some or all of the tasks performed by the physician assistant." (Bus. & Prof. Code, § 3502, subd. (c).) Those protocols must comply with certain requirements:

> (1)(A) A protocol governing diagnosis and management shall, at a minimum, include the presence or absence of symptoms, signs, and other data necessary to establish a diagnosis or assessment, any appropriate tests or studies to order, drugs to recommend to the patient, and education to be provided to the patient. [¶] . . . [¶]
>
> (2)(A) The supervising physician and surgeon shall use one or more of the following mechanisms to ensure adequate supervision of the physician assistant functioning under the protocols:
>
> (i) The supervising physician and surgeon shall review, countersign, and date a sample consisting of, at a minimum, 5 percent of the medical records of patients treated by the physician assistant functioning under the protocols within 30 days of the date of treatment by the physician assistant. [¶] . . . [¶]

(2)(B) In complying with paragraph (A), the supervising physician and surgeon shall select for review those cases that by diagnosis, problem, treatment, or procedure represent, in his or her judgment, the most significant risk to the patient.

(Bus. & Prof. Code, § 3502, subd. (c).) Compliance with section 3502 is deemed compliance with CCR section 1399.546. (Bus. & Prof. Code, § 3502, subd. (f).)

8. "Because physician assistant practice is directed by a supervising physician, and a physician assistant acts as an agent for that physician, the orders given and tasks performed by a physician assistant shall be considered the same as if they had been given and performed by the supervising physician. Unless otherwise specified in these regulations or in the delegation or protocols, these orders may be initiated without the prior patient specific order of the supervising physician." (CCR, § 1399.541.) A physician assistant may, under a delegation and protocols, "[t]ake a patient history; perform a physical examination and make an assessment and diagnosis therefrom; initiate, review and revise treatment and therapy plans including plans for those services . . . ; and record and present pertinent data in a manner meaningful *to the physician.* (CCR, § 1399.541, subd. (a), italics added.) A physician assistant may, among other things, order x-rays, laboratory tests, and therapeutic services, counsel patients on matters pertaining to their health, and provide and order medication. (CCR, § 1399.541.)

9. CCR section 1399.545 provides:

(a) A supervising physician shall be available in person or by electronic communication at all times when the physician assistant is caring for patients.

(b) A supervising physician shall delegate to a physician assistant only those tasks and procedures consistent with the supervising physician's specialty or usual and customary practice and with the patient's health and condition.

(c) A supervising physician shall observe or review evidence of the physician assistant's performance of all tasks and procedures to be delegated to the physician assistant until assured of competency. [¶] . . . [¶]

(e) A physician assistant and his or her supervising physician shall establish in writing guidelines for the adequate supervision of the physician assistant which shall include one or more of the following mechanisms: [¶] . . . [¶]

(3) . . . Protocols shall be signed and dated by the supervising physician and the physician assistant. The supervising physician shall review, countersign, and date a minimum of 5% sample of medical records of patients treated by the physician assistant functioning under these

protocols within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent, in his or her judgment, the most significant risk to the patient; [¶] . . . [¶].

(f) The supervising physician has continuing responsibility to follow the progress of the patient and to make sure that the physician assistant does not function autonomously. The supervising physician shall be responsible for all medical services provided by a physician assistant under his or her supervision.

10. "The medical record, for each episode of care for a patient, shall identify the physician and surgeon who is responsible for the supervision of the physician assistant." (Bus. & Prof. Code, § 3502, subd. (a).) "Each time a physician assistant provides care for a patient and enters his or her name, signature, initials, or computer code on a patient's record, chart or written order, the physician assistant shall also enter the name of his or her supervising physician who is responsible for the patient." (CCR, § 1399.546.)

11. Respondent complied with his obligation to review at least five percent of each PA's monthly patient charts. (Factual Finding 9.) Complainant does not allege that the process for selecting charts for review did not comply with statutory and regulatory requirements. And importantly, complainant did not introduce into evidence any charts that respondent did review in the normal course of complying with his statutory duties. But the evidence established that respondent did not comply with his supervisory duties sufficiently to ensure that records were accurate and adequate and that they identified the supervising physician.

Cause for Discipline

12. Cause does not exist to discipline respondent's certificate pursuant to Business and Professions Code section 2234, subdivision (b), for engaging in gross negligence in connection with his supervision of PA's and the care and treatment provided to Patients A.H., D.E., E.A., M.P., and H.A., by reason of Factual Findings 6 through 48 and Legal Conclusions 1 through 11.

13. Cause does not exist to discipline respondent's certificate pursuant to Business and Professions Code section 2234, subdivision (d), for repeated negligent acts in connection with his supervision of P.A.'s and the care and treatment provided to Patients A.H., D.E., E.A., M.P., and H.A., by reason of Factual Findings 6 through 48 and Legal Conclusions 1 through 11.

14. Cause exists to discipline respondent's certificate pursuant to Business and Professions Code sections 2234, subdivision (a), and 2266 for inadequate recordkeeping in connection with his supervision of P.A.'s and the care and treatment provided to Patients A.H., D.E., E.A., M.P., and H.A., by reason of Factual Findings 6 through 48 and Legal Conclusions 1 through 11.

15. Cause exists to discipline respondent's certificate pursuant to Business and Professions Code sections 2234, subdivision (a), 2266, and 3502, for failure to document his supervision of his PA's in connection with his the care and treatment provided to Patients A.H., D.E., E.A., M.P., and H.A., by reason of Factual Findings 6 through 48 and Legal Conclusions 1 through 11.

16. The evidence presented in respondent's favor demonstrates that he sought to provide protocols, resources, and guidance for his PA's and was always available to answer questions by telephone. It was not established that the care provided by the PA's to Patients A.H., D.E., E.A., M.P., and H.A., for which respondent was responsible, constituted extreme or repeated departures from the standard of care. But complainant has clearly and convincingly established that, in the documentation of care provided by respondent's PA's, respondent repeatedly acted in violation of the Medical Practice Act and of statutory and regulatory provisions governing the professional practice of medicine. The records did not identify respondent as the supervising physician. Some records lacked information about the patient's vital signs, about details of the patient's relevant history, and about the patient's examination. Many of the records were illegible. The rationale for some treatment provided by the PA's was not apparent from the patient records. The purpose of a disciplinary action such as this is to protect the public, and not to punish the licensee. (*Camacho v. Youde* (1979) 95 Cal.App.3d 161, 164; *Small v. Smith* (1971) 16 Cal.App.3d 450, 457.) Accordingly, the Order that follows is both necessary and sufficient for the protection of the public.

ORDER

Physician's and Surgeon's Certificate No. G 75144, issued to respondent Raymond M. Menchaca, M.D., is hereby revoked. The revocation is stayed, however, and respondent's certificate is placed on probation for five years on the following terms and conditions:

1. **Notification**

Within seven (7) days of the effective date of this Decision, the respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

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2. **Obey All Laws**

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

3. **Quarterly Declarations**

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

4. **General Probation Requirements**

Compliance with Probation Unit: Respondent shall comply with the Board's probation unit.

Address Changes: Respondent shall, at all times, keep the Board informed of respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice: Respondent shall not engage in the practice of medicine in respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal: Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California: Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event respondent should leave the State of California to reside or to practice respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

5. **Interview with the Board or its Designee**

Respondent shall be available in person upon request for interviews either at respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

6. **Non-practice While on Probation**

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of respondent's return to practice. Non-practice is defined as any period of time respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If respondent resides in California and is considered to be in non-practice, respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event respondent's period of non-practice while on probation exceeds 18 calendar months, respondent shall successfully complete the Federation of State Medical Board's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a respondent residing outside of California, will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

7. **Completion of Probation**

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

8. **Violation of Probation**

Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Board, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary

order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

9. **License Surrender**

Following the effective date of this Decision, if respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request to surrender his license. The Board reserves the right to evaluate respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Board or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

10. **Probation Monitoring Costs**

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

11. **Education Course**

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

12. **Prescribing Practices Course**

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after respondent's initial enrollment. Respondent shall successfully complete any other

component of the course within one (1) year of enrollment. The prescribing practices course shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

13. **Medical Record Keeping Course**

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

14. **Professionalism Program (Ethics Course)**

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The

professionalism program shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

15. **Clinical Competence Assessment Program**

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require respondent's on-site participation for a minimum of 3 and no more than 5 days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the respondent has demonstrated the ability to practice safely and independently. Based on respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

If respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, respondent shall receive

a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If the respondent did not successfully complete the clinical competence assessment program, the respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

Within 60 days after respondent has successfully completed the clinical competence assessment program, respondent shall participate in a professional enhancement program approved in advance by the Board or its designee, which shall include quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation, or until the Board or its designee determines that further participation is no longer necessary.

16. **Monitoring - Practice**

Within 30 calendar days of the effective date of this Decision, respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in respondent's field of practice, and must agree to serve as respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, respondent's physician assistant supervision practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so

notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of respondent's performance, indicating whether respondent's physician assistant supervision practices are within the standards of practice of medicine, and whether respondent is practicing medicine safely. It shall be the sole responsibility of respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, respondent may participate in a professional enhancement program approved in advance by the Board or its designee, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation.

DATED: June 21, 2017

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HOWARD W. COHEN
Administrative Law Judge
Office of Administrative Hearing

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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **RAYMOND M. MENCHACA, M.D.** **852 Ventura Street** **Fillmore, CA 93015** **Physician's and Surgeon's Certificate No. G 75144,** Respondent.	Case No. 11-2013-233166 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about September 8, 1992, the Medical Board issued Physician's and Surgeon's Certificate Number G 75144 to Raymond M. Menchaca, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2018, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"...."

6. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

7. Section 3501 of the Code states in pertinent part:

"(a) As used in this chapter:

"...

"(5) "Supervising physician" means a physician and surgeon licensed by the Medical Board of California or by the Osteopathic Medical Board of California who supervises one or more physician assistants, who possesses a current valid license to practice medicine, and who is not currently on disciplinary probation for improper use of a physician assistant.

"(6) "Supervision" means that a licensed physician and surgeon oversees the activities of, and accepts responsibility for, the medical services rendered by a physician assistant.

"...

"(10) "Delegation of services agreement" means the writing that delegates to a physician assistant from a supervising physician the medical services the physician assistant is authorized to perform consistent with subdivision (a) of Section 1399.540 of Title 16 of the California Code of Regulations.

"...

"(b) A physician assistant acts as an agent of the supervising physician when performing any activity authorized by this chapter or regulations adopted under this chapter."

8. Section 3502, subdivision (a), of the Code states in pertinent part:

"(a) Notwithstanding any other law, a physician assistant may perform those medical services as set forth by the regulations adopted under this chapter when the services are rendered under the supervision of a licensed physician and surgeon who is not subject to a disciplinary condition imposed by the Medical Board of California prohibiting that supervision or prohibiting the employment of a physician assistant. The medical record, for each episode of care for a patient, shall identify the physician and surgeon who is responsible for the supervision of the physician assistant."

9. California Code of Regulations, Title 16, section 1399.541 states as follows:

"Because physician assistant practice is directed by a supervising physician, and a physician assistant acts as an agent for that physician, the orders given and tasks performed by a

physician assistant shall be considered the same as if they had been given and performed by the supervising physician. Unless otherwise specified in these regulations or in the delegation or protocols, these orders may be initiated without the prior patient specific order of the supervising physician. In any setting, including for example, any licensed health facility, out-patient settings, patients' residences, and hospices, as applicable, a physician assistant may, pursuant to a delegation and protocols where present:

"(a) Take a patient history; perform a physical examination and make an assessment and diagnosis therefrom; initiate, review and revise treatment and therapy plans including plans for those services described in Section 1399.541(b) through Section 1399.541(i) inclusive; and record and present pertinent data in a manner meaningful to the physician.

"(b) Order or transmit an order for x-ray, other studies, therapeutic diets, physical therapy, occupational therapy, respiratory therapy, and nursing services.

"(c) Order, transmit an order for, perform, or assist in the performance of laboratory procedures, screening procedures and therapeutic procedures.

"(d) Recognize and evaluate situations which call for immediate attention of a physician and institute, when necessary, treatment procedures essential for the life of the patient.

"(e) Instruct and counsel patients regarding matters pertaining to their physical and mental health. Counseling may include topics such as medications, diets, social habits, family planning, normal growth and development, aging, and understanding of and long-term management of their diseases.

"(f) Initiate arrangements for admissions, complete forms and charts pertinent to the patient's medical record, and provide services to patients requiring continuing care, including patients at home.

"(g) Initiate and facilitate the referral of patients to the appropriate health facilities, agencies, and resources of the community.

"(h) Administer or provide medication to a patient, or issue or transmit drug orders orally or in writing in accordance with the provisions of subdivisions (a)-(f), inclusive, of Section 3502.1 of the Code.

"(i) (1) Perform surgical procedures without the personal presence of the supervising physician which are customarily performed under local anesthesia. Prior to delegating any such surgical procedures, the supervising physician shall review documentation which indicates that the physician assistant is trained to perform the surgical procedures. All other surgical procedures requiring other forms of anesthesia may be performed by a physician assistant only in the personal presence of an approved supervising physician.

"(2) A physician assistant may also act as first or second assistant in surgery under the supervision of an approved supervising physician. The physician assistant may so act without the personal presence of the supervising physician if the supervising physician is immediately available to the physician assistant. "Immediately available" means the physician is physically accessible and able to return to the patient, without any delay, upon the request of the physician assistant to address any situation requiring the supervising physician's services."

10. California Code of Regulations section 1399.545 states, in pertinent part, as follows:

"...

"(f) The supervising physician has continuing responsibility to follow the progress of the patient and to make sure that the physician assistant does not function autonomously. The supervising physician shall be responsible for all medical services provided by a physician assistant under his or her supervision."

11. California Code of Regulations section 1399.546 states as follows:

"Each time a physician assistant provides care for a patient and enters his or her name, signature, initials, or computer code on a patient's record, chart or written order, the physician assistant shall also enter the name of his or her supervising physician who is responsible for the patient. When a physician assistant transmits an oral order, he or she shall also state the name of the supervising physician responsible for the patient."

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FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

12. Respondent Raymond M. Menchaca, M.D. is subject to disciplinary action under Code section 2234, subdivision (b) in that he committed gross negligence in his care and treatment of Patients A.H., D.E., E.P., E.A., M.P. and H.A.[1] The circumstances are as follows:

13. Respondent is board certified in family medicine.

14. Since 2006 and, thus, at all times relevant to the allegations contained herein, Respondent was a part owner and salaried employee of Zacoalco Medical Group, Inc. (Zacoalco).

15. Zacoalco is comprised of two family care medical clinics: one located in Bakersfield, California and the other at 1414 E. Florence Avenue, Los Angeles, California 90001. Respondent alternates working at each clinic on Thursdays and occasionally on Saturdays. He typically spends Monday, Tuesday, Wednesday and Friday working at another unrelated clinic.

16. Patients are primarily treated at the Zacoalco clinics by physician assistants.

17. In California, physician assistants require a supervising physician. The ultimate responsibility for ensuring the quality of patient care and safety rests on the supervising physician. If care provided by a physician assistant falls below the applicable standard of care, the supervising physician is responsible for remedying the deficiency in the care provided. When a supervising physician co-signs a patient's progress note, the signature signifies the physician's agreement with the care given to the patient and to the documentation in the medical records as maintained by the physician assistant unless otherwise specified in writing by the physician on the progress note.

18. At all times relevant herein and pursuant to delegation of services agreements, Respondent was the supervising physician for all of the physician assistants at Zacoalco. Accordingly, he was responsible for all of the patient care provided by the Zacoalco physician assistants as described herein.

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[1] Initials are used to protect patient privacy.

19. The standard of care dictates that when treating a patient and creating a treatment plan an appropriate prior examination (including, for example, sufficient components of vital signs, history of the presenting acute and chronic problems, past medical history, physical examination, and testing) is necessary. The standard of care requires that an examination appropriate for the presenting complaint, or chronic diagnosis, be conducted.

20. The standard of care also dictates that the patient's history and examination be documented in the patient's medical record. The documentation in a patient's medical record must reflect the patient's presenting problems or complaints, including sufficient components of history, review of symptoms and the physical examination. Further, the documentation must be sufficient to determine the diagnosis, or most probable diagnosis, and whether the condition is stable or unstable, such that guidance is given to the needed examination and any additional testing, if necessary. The history and documentation thereof must also be sufficient to justify any medications prescribed.

21. The standard of care further dictates that a patient's medical chart must be legible for review by trained medical professionals. There are many purposes of the medical record, including to provide clinical information regarding what was stated and done at the visit for the treating provider as a reminder, for other providers who may care for the patient in the future, for quality reviews, and for billing purposes, among others. This information must be legible, not only to the provider, but also to other reviewers.

Patient A.H.

22. On or about October 25, 2012, Patient A.H. presented at Zacoalco, where she received medical care and treatment from two physician assistants.

23. According to Patient A.H.'s medical records, the purpose of her October 25, 2012 visit was to refill medication.

24. Patient A.H. had previously been diagnosed with asthma and hypertension. At the October 25, 2012 visit, she was administered Clonidine after having a high blood pressure reading. There is no documentation in her chart, however, that after receiving the Clonidine her blood pressure was taken again at this visit, as required by the applicable standard of care.

25. Most of the notes in Patient A.H.'s medical record for this visit are not legible. It appears, however, that injections of Rocephin, an antibiotic, and Decadron, a corticosteroid hormone, were ordered. The reason(s) for administering these injections is not reflected in Patient A.H.'s records.

26. It also appears from the record of her October 25, 2012 visit, that Patient A.H. received a nebulizer treatment; however, there is no documentation of a need for the nebulizer treatment; and her lung exam was normal.

27. Patient A.H. again presented at Zacoalco on or about December 27, 2012 and was again treated by a physician assistant.

28. According to Patient A.H.'s medical records, the purpose of her December 27, 2012 visit was to obtain lab results. The lab results showed that A.H. had anemia.

29. Anemia can result from numerous causes, including blood loss, nutritional abnormalities, bone marrow deficiencies or diseases, infection or inflammation, chronic disease, and malignancy, among others. It is the standard of care that once laboratory results demonstrate that a patient is anemic that a search for an etiology be undertaken to identify the appropriate course of treatment. This endeavor would include taking a medical history, including a medication history, to search for possible causes and symptoms of the anemia. A general exam, including a stool test, should also be conducted.

30. At the December 27, 2012 visit, there is no medical history documented, including an adequate history of Patient A.H.'s anemia, nor is Patient A.H.'s blood pressure documented, despite her previous diagnosis of hypertension.

31. Patient A.H. was again given a nebulizer treatment, but the reason is not documented.

32. During the course of Patient A.H.'s care and treatment at Zacoalco:

a. A.H.'s past medical history was insufficiently documented to justify the medications prescribed;

b. The examinations performed on A.H. were minimal and insufficient to justify the medications and treatments prescribed;

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c. An appropriate examination was not performed at her December 27, 2012 visit pertaining to her anemia, including performing a rectal exam, nor was an appropriate anemia evaluation performed, including additional laboratory testing;

d. Medications were prescribed with no documented justification or explanation;

e. Diagnoses were listed without supporting information;

f. Injection medications were administered without justification;

g. Nebulizer treatments were given without adequate justification; and

h. Illegible notes were made in her chart, including but not limited to those pertaining to physical examinations, assessments and treatment plans.

33. Respondent's failure to adequately supervise, evaluate, manage and document A.H.'s care on multiple dates constitutes an extreme departure from the standard of care.

Patient D.E.

34. Between October 2012 and April 2014, Patient D.E. presented at Zacoalco numerous times, where he received medical care and treatment from physician assistants.

35. On numerous visits, Patient D.E. presented with bronchitis or an upper respiratory infection and was treated with injections of medications including, Dexamethasone IM and prednisone, both steroids.

36. During the course of Patient D.E.'s care and treatment at Zacoalco:

a. D.E.'s past medical history was insufficiently documented to justify the medications prescribed;

b. The examinations performed on D.E. were minimal and insufficient to justify the medications and treatments prescribed;

c. Medications were prescribed with no documented justification or explanation;

d. Diagnoses were listed without supporting information;

e. Injection medications were administered without justification; and

f. Illegible notes were made in his chart, including but not limited to those pertaining to physical examinations, assessments and treatment plans.

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37. Respondent's failure to adequately supervise, evaluate, manage and document D.E.'s care on multiple dates constitutes an extreme departure from the standard of care.

Patient E.P.

38. Between December 27, 2010 and December 18, 2013, Patient E.P. presented at Zacoalco on at least twenty different occasions and was treated by various physician assistants. E.P.'s chief complaint was generally pain, particularly pelvic pain. On multiple visits despite Patient E.P.'s complaint of pelvic pain, no pelvic examination was performed. The purpose of many of her visits was to follow up on laboratory results.

39. On or about May 14, 2011, Patient E.P. presented at Zacoalco, where she was treated by a physician assistant. According to Patient E.P.'s medical records, she was suffering from pain in her left breast and gastritis. Among other medications, the physician assistant prescribed Bactrim, an antibiotic, however, there is no indication in her record of a bacterial infection.

40. During the course of Patient E.P.'s care and treatment at Zacoalco:

a. E.P.'s past medical history was insufficiently documented to justify the medications prescribed;

b. The examinations performed on E.P. were minimal and insufficient to justify the medications and treatments prescribed;

c. E.P. complained of pelvic pain at multiple visits, yet pelvic examinations were not performed;

d. Medications were prescribed with no documented justification or explanation;

e. Diagnoses were listed without supporting information;

f. Injection medications were administered without justification; and

g. Illegible notes were made in her chart, including but not limited to those pertaining to physical examinations, assessments and treatment plans.

41. Respondent's failure to adequately supervise, evaluate, manage and document E.P.'s care on multiple dates constitutes an extreme departure from the standard of care.

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Patient E.A.

42. Between March 5, 2010 and November 21, 2013, Patient E.A. presented at Zacoalco on at least twenty different occasions and was treated by various physician assistants. E.A. sought treatment and medication management for hypertension and elevated glucose levels, among other conditions.

43. During the course of Patient E.A.'s care and treatment at Zacoalco:

a. E.A.'s past medical history was insufficiently documented to justify the medications prescribed;

b. The examinations performed on E.A. were minimal and insufficient to justify the medications and treatments prescribed;

c. Medications were prescribed with no documented justification or explanation;

d. Diagnoses were listed without supporting information; and

e. Illegible notes were made in his chart, including but not limited to those pertaining to physical examinations, assessments and treatment plans.

44. Respondent's failure to adequately supervise, evaluate, manage and document E.A.'s care on multiple dates constitutes an extreme departure from the standard of care.

Patient M.P.

45. Between November 19, 2009 and November 27, 2013, Patient M.P. presented at Zacoalco on at least thirty-five different occasions and was treated by various physician assistants. M.P.'s complaints included allergies, sinusitis, breast and lower back pain, and eczema.

46. During the course of Patient M.P.'s care and treatment at Zacoalco:

a. M.P.'s past medical history was insufficiently documented to justify the medications prescribed;

b. The examinations performed on M.P. were minimal and insufficient to justify the medications and treatments prescribed;

c. Medications were prescribed with no documented justification or explanation;

d. Diagnoses were listed without supporting information;

e. Injection medications were administered without justification; and

f. Illegible notes were made in her chart, including but not limited to those pertaining to to physical examinations, assessments and treatment plans.

47. Respondent's failure to adequately supervise, evaluate, manage and document M.P.'s care on multiple dates constitutes an extreme departure from the standard of care.

Patient H.A.

48. Between June 2, 2009 and February 11, 2014, Patient H.A. presented at Zacoalco on at least fifteen different occasions and was treated by various physician assistants. Her chief complaints included back, neck, shoulder, elbow and kidney pain.

49. On or about May 31, 2011, Patient H.A. presented at Zacoalco, where she was treated by a physician assistant. H.A.'s chief complaints were anxiety, headache, dizziness, nausea and muscle spasm. Patient H.A.'s treatment included an injection of Toradol, a nonsteroidal anti-inflammatory drug.

50. On or about November 17, 2012, Patient H.A. presented at Zacoalco, where she was treated by two physician assistants. Patient H.A. complained of inflammation and pelvic pain, headache and dizziness. Patient H.A. was treated with injections of Cipro and Rocephin, both antibiotics.

51. During the course of Patient H.A.'s care and treatment at Zacoalco:

a. H.A.'s past medical history was insufficiently documented to justify the medications prescribed;

b. The examinations performed on H.A. were minimal and insufficient to justify the medications and treatments prescribed;

c. Medications were prescribed with no documented justification or explanation;

d. Diagnoses were listed without supporting information;

e. Injection medications were administered without justification; and

f. Illegible notes were made in her chart, including but not limited to those pertaining to physical examinations, assessments and treatment plans.

52. Respondent's failure to adequately supervise, evaluate, manage and document H.A.'s care on multiple dates constitutes an extreme departure from the standard of care.

53. With respect to each and every patient discussed herein there is no evidence in their respective records of Respondent's involvement in, or review of, the care provided by any of the physician assistants that he was responsible for supervising. For example, there is no evidence in any of these patients' medical records that Respondent had any discussion with any of the treating physician assistants regarding the patient's care. Likewise, Respondent did not co-sign or correct any of the records.

54. The totality of the care provided to these patients demonstrate a pattern of the excessive use of injectable medications and other treatments without having taken, developed or documented an adequate history, exam, diagnoses and management plan. Respondent was responsible for ensuring that the care and treatment provided by the physician assistants and his supervision met the standard of care.

55. Though Respondent admits that the physician assistants' records were often illegible, the frequent and consistent poor legibility of the physician assistants' records does not appear to have been adequately addressed by Respondent as the legibility of the patients' records show no improvement over time.

56. Respondent admits that if a chart he reviewed was illegible, his practice was not to correct it.

57. Respondent's supervision of the physician assistants' practice of medicine with respect to the above-listed patients was inadequate and inappropriate such that it constitutes an extreme departure from the standard of care with respect to each patient.

58. Respondent's acts and/or omission as set forth in paragraphs 14 through 58, inclusive above, whether proven individually, jointly, or in any combination therefore, constitute gross negligence pursuant to section 2234, subdivision (b), of the Code. As such, cause for discipline exists.

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SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

59. Respondent Raymond M. Menchaca, M.D. is subject to disciplinary action under Code section 2234, subdivision (c) in that he committed repeated negligent acts in his care and treatment of Patients A.H., D.E., E.P., E.A., M.P. and H.A. The circumstances are as follows:

60. Paragraphs 14 through 57 are incorporated by reference and re-alleged as if fully set forth herein.

61. Respondent's acts and/or omission as set forth in paragraphs 14 through 57, inclusive above, whether proven individually, jointly, or in any combination therefore, constitute repeated negligent acts pursuant to section 2234, subdivision (c), of the Code. As such, cause for discipline exists.

THIRD CAUSE FOR DISCIPLINE

(Inadequate Record Keeping)

62. Respondent Raymond M. Menchaca, M.D. is subject to disciplinary action under Code section 2234, subdivision (a), and 2266 in that he failed to maintain adequate records concerning the care and treatment of Patients A.H., D.E., E.P., E.A., M.P. and H.A. The circumstances are as follows:

63. Paragraphs 14 through 57 are incorporated by reference and re-alleged as if fully set forth herein.

64. Respondent's acts and/or omission as set forth in paragraphs 14 through 57, inclusive above, whether proven individually, jointly, or in any combination therefore, constitute inadequate record keeping in violation of Code section 2234, subdivision (a), and 2266 and cause for discipline exists.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Document Supervision of Physician Assistants)

65. Respondent Raymond M. Menchaca, M.D. is subject to disciplinary action under Code section 2234, subdivision (a), 2266, 3502, subdivision (a), and California Code of Regulations, Title 16, section 1399.546 in that despite being the supervising physician at Zacoalco

he is not identified as the supervising physician in the medical records of Patients A.H., D.E., E.P., E.A., M.P. and H.A., nor did he counter sign any of these patients' medical records. The circumstances are as follows:

66. Paragraphs 14 through 57 are incorporated by reference and re-alleged as if fully set forth herein.

67. Respondent's acts and/or omission as set forth in paragraphs 14 through 57, inclusive above, whether proven individually, jointly, or in any combination therefore, constitute failure to document supervision of physician assistants in violation of Code section 2234, subdivision (a), 2266, 3502, subdivision (a), and California Code of Regulations, Title 16, section 1399.546 and cause for discipline exists.

PRAYER.

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 75144, issued to Raymond M. Menchaca, M.D.;

2. Revoking, suspending or denying approval of Raymond M. Menchaca, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering Raymond M. Menchaca, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: May 19, 2016

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant